CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN - OPTIONAL)*

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the client *(except drug or alcohol abuse diagnoses or treatment information)* to be exchanged:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits /Services Needed Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

Other Information (write in):

I want: _____

_____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

Are More Agencies Listed on Back? YES ☐ NO ☐

I want this information to be exchanged ONLY for the following purpose(s):

☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

Other (write in): _____

I want information to be shared: (check all that apply)

☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until: _____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): _____ **Date:** _____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) *(Title)* *(Phone Number)*

Witness (If Required): _____
(Signature) *(Address)* *(Phone Number)*

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